

matter of focusing the interest regarding tropical medicine in these columns. We should especially like to hear more from the southern part of the State. May we suggest that every physician who meets with an instructive case communicate with us? There is no doubt but that every reader of the JOURNAL who is interested in scientific medicine will greatly appreciate such information.

### DERMATITIS FACTITIA IN A PATIENT WITH PRURITUS GENERALIS—A CASE REPORT.

By HARRY E. ALDERSON, M. D., San Francisco.

This condition is uncommon enough to warrant the reporting of cases, and the following is an account of one recently seen in the practice of the writer, presenting some peculiar features.

Mrs. X. Age 62+. Widow. Vocation: At present she devotes all her time to the relief of her symptoms. She formerly conducted a fake medical institute. She is poorly nourished, very nervous and a pronounced hypochondriac. She has had pruritus generalis, formication being a marked feature, for four years. She states that the excitement during the great fire in San Francisco and the trying times following were responsible for its onset. She cherishes the interesting theory that her "system is full of a gritty substance which is gradually working its way through the skin where it causes intolerable crawling sensations, etc." To "capture" these grains, she gouges out a piece of epidermis at the proper psychological moment and is rewarded by instant relief, whereupon she awaits with poised thumb, the appearance of this sensation elsewhere and then promptly scoops out more epidermis. This performance occurs daily. The superficial lacerations that she thus induces are of about the width of her thumb nail and from one-half to one-inch or more long. They are usually straight in their direction; but often form slight curves. She always immediately cleanses the wound and so it soon crusts over and heals. A white, faintly marked, permanent scar, surrounded by a narrow zone of dark pigmentation, results. This pigmentation is an interesting feature and is probably due to the fact that the pigment cells are naturally in a state of increased activity at her age (62+), and also that they are often very active in itching dermatoses where there is much rubbing or scratching. Her body is covered with these scars, so that hardly any space is left for new lesions.

She is improving very much under suggestive treatment and the following medication: Strontium bromide (gr. 10) every four hours, and tincture rhei every three or four days; also a lotion composed of liquor carbonis detergens, zinc oxide, calamine, liquor calcis, and oleum amygdal. dulc. She is gradually learning to rub this on in place of the destructive scoop with her thumb nail.

This patient presents a condition allied to acarophobia, the usual accompaniment of pruritus senilis. Instead of imagining that the sensations are due to parasites, however, she blames "migratory grains of sand" for her trouble. The universality of the symptoms and the fact that they occur the same throughout the year, are rather unusual features. The patient's skin is fine and delicate, but rather dry. Very little evidence of senile degeneration, aside from thinness and dryness, is apparent, and so one usually finds the skin to be in pruritus senilis.

The foregoing record well illustrates the impor-

tance of avoiding haste in making a diagnosis. Without carefully examining and investigating this case, one could easily go astray in naming the disease. The peculiar white scars, with surrounding zones of pigmentation, might be very misleading in the absence of any history or general observation of the patient.

## SOCIETY REPORTS

### SONOMA COUNTY.

Regular meeting, Petaluma, Jan. 7, 1910.

1. Address, President S. Z. Peoples, "The Plans and Aspirations of Our Society for 1910."

After briefly reviewing the history and work of the Society, he expressed himself briefly as follows:

That if our Society accomplished nothing more than getting its members better acquainted, it would serve a useful purpose. That we expect and hope to have at each meeting in the current year some live practical subject for consideration and clinical material whenever possible and that the entire membership shall freely enter into the discussion. That our county fee bill should be supported at least as to a minimum charge, and that our bills when presented bear not less than this minimum charge. That every eligible physician in the county should be induced to join the Society.

"I wish to advocate here what has been suggested before but never put into action, the organization of the physicians of each community into a local society." Their sphere of action to be, to fix distance fees to certain well known landmarks, deal with questions arising with the local pharmacists, matters of sanitation, public health, etc. "I wish to remind you right here, of our duty in reporting contagious diseases and births to the proper authorities. We should not allow ourselves to be reminded of these duties by arrests made for neglecting them. Let us endeavor to eliminate 'deadbeats' as much as possible from our service, compiling a 'blacklist' if necessary."

That we consider the attitude of local pharmacists toward the profession, and possibly meet with them for the consideration of matters of mutual interest and probably send a circular letter to all the druggists of the county defining our attitude in our relations with them.

"Let us devote more attention to the commercial end of our business."

"Stand together for mutual protection and advancement of the profession and keep in mind that a kind act or a kind word for a brother practitioner will profit you more than unfair criticism and disparagement of another."

2. Paper—Dr. Marion B. McAulay. Appendicitis. After briefly referring to the attention this subject has and is receiving in all fields of medical work and literature and briefly relating its historical significance, the doctor presented the following points notably among others:

Above all things success in handling and curing appendicitis at the present time lies in making "a quick and accurate diagnosis, for without relation to present signs and symptoms a case may result in rupture within one hour." Refers briefly to the anatomical position and relations of the appendix and the difference in opinion among well known surgeons and anatomists, giving as her personal

(Patient exhibited before the University of California Medical Alumni Association.)

opinion that though many authorities describe the organ as being curled upon itself that the curling of the organ is due to adhesions and the formation of constriction bands as the result of inflammatory processes. Briefly notes the manner of classifying different inflammatory processes of the appendix. Calls particular attention to the fact that the same etiological conditions may be found here as elsewhere in the body with the same causal agents. More frequently here than elsewhere, due to the proximity of the intestinal canal; the infecting agent is *b. coli comunis*, and most infections arise from the mucous lining. The appendix being a blind sack, when inflammatory processes arise within it tumefaction at the proximal end closes its only outlet. Then, by the accumulation of pus and serum the sack is distended and goes on to rupture or gangrene with localized peritonitis which may become diffuse or by the adhesion of adjacent portions of the peritoneum may form a walled-in abscess. This train of events has given two methods of treatment: Immediate operation to prevent rupture and peritonitis or: Expectant to allow time for the formation of a walled-in abscess.

There is a classical symptom complex for appendicitis but to obtain results one cannot wait for this classical picture to make a diagnosis for any one or more of these symptoms may be lacking. A sudden decrease in temperature with a rise in the pulse rate and a cessation of the subjective symptoms must be treated with suspicion. Medical treatment consists in rest and the application of heat or cold applications. Ice if the temperature is high and heat if there is much pain. Dr. McAulay does not know any reason why water should be withheld and rather encourages its use. Advises the use of castor oil repeated as frequently as necessary, using also high enemata of saline solution, soapsuds, milk and molasses or epsom salts three times daily. With frequent enemata, patients who have been very constipated will pass large masses of feces, followed by quantities of scybala and finally mucus and pus. Prefers operation in every case, because a positive diagnosis of the condition of the appendix can be made only by seeing the organ itself. In case of ruptured appendix the Mayos recommend doing all that is possible in ten minutes and completing at a subsequent operation, thus saving the patient from the effects of a long continued anesthetic. Dr. McAulay does not agree with this method of procedure, except when the patient is in extremis. She prefers to remove all that is offending at the first operation. The doctor recommends Dr. O'Brien's method of carefully sponging out the abscess cavity, disturbing the surrounding structures as little as possible, by slowly and carefully inserting sponges on long sponge holders until the bottom of the cavity is reached and the diseased area exposed for operative procedure. On first opening the abscess the walled-in pus is allowed to well out until a clear field is left for further procedure. Finally closing the wound leaving a drain which reaches to the bottom of the cavity.

Prognosis: There are no statistics offered for un-operated cases while less than 1% recover with late operation. The deaths result from both delay and sepsis. Out of 25 cases operated Dr. McAulay reports no deaths.

"Operation is simple and safe in uncomplicated cases, convalescence is short and cure certain, while after the appendix has ruptured the patient is not in condition for an easy operation or a long convalescence."

3. Operative Technique (in conjunction with Dr. McAulay's paper). Dr. J. T. O'Brien.

The classical gridiron incision is ideal when we are positive there is no pus. But this route gives

room for only two fingers to enter and insufficient room in which to operate. So it is often necessary to extend the incision into the sheath of the rectus, often finding the epigastric artery in the way. As a consequence he prefers an oblique incision through the linea semilunaris. The gridiron incision, after the operation allows the tissues to resume their normal positions and relations, even being proof against injury during post operative vomiting, but is at the same time a hindrance to easy drainage. If the semilunar line cannot be found there is no harm done by going through the right rectus itself, provided the two layers of fascia are found and secured upon sewing up the abdomen.

The treatment of the appendix must depend upon the condition in which it is found. If ready to rupture clamp it with two clamps and cut between, always carefully ligating the mesoappendix. Treat the stump with carbolic acid and return the cecum to the peritoneal cavity. If there is time a purse string suture may be drawn about the base of the appendix, but this is not essential. There is some danger that clamping the appendix alone will not obliterate all its vessels and hemorrhage may result. Usually treatment with carbolic acid and alcohol are sufficient to prevent this. Always remove the appendix if possible and as early as possible after a diagnosis of appendicitis is made. In sewing up the wound use plain catgut for the peritoneum, chrome gut for the fascia and silkworm gut for the skin. If haste is necessary, use through and through silkworm gut. If there is much fat in the areolar tissue of the skin, make wide stitches, as the fat between the sutures will atrophy and the skin would otherwise pull out leaving a broad, unsightly scar.

#### Discussion.

Dr. Bonar. Why do you use silkworm gut in the skin?

Dr. O'Brien. For their strength and the fact that I believe they can be sterilized and do not become a culture medium for bacteria.

Dr. Briggs. Do you irrigate the peritoneal cavity with salt solution?

Dr. O'Brien. No, but I use normal salt enemata for stimulation and also because by so doing I find my patients suffer less from thirst.

Dr. Temple. Large sponges are used to protect the rest of the peritoneal cavity from contamination?

Dr. McAulay. We believe the introduction of large sponges irritates the peritoneum covering the bowels and adds to the shock, and also that it is not necessary if careful technic is employed in using sponges on sponge holders.

Adjourned to meet in Cloverdale in February.

JACKSON TEMPLE,  
Secretary.

## BOOK REVIEWS

**Medical Gynecology.** By S. W. Bandler, M. D. Publishers, W. B. Saunders Co. 1909.

The second edition of Dr. Bandler's text-book of Medical Gynecology appearing, as it does, so shortly after the first, one would hardly look for many changes—the only new feature being the introduction of Dr. Head's surface markings as an aid to diagnosis.

The author covers the subject in a very thorough manner, the chapters on Gonorrhea and Hydrotherapy in particular being well done. Repetitions however are far too numerous and the volume could be materially reduced, adding much to the comfort of the student.

W. G. M.